2007 Medical Plan Summary
Anthem Blue Cross/Blue Shield (BCBS) Plan

Levels of Coverage:

Tier I	Employee Only	Tier III	Employee & Children
Tier II	Employee & Spouse/Registered Partner	Tier IV	Employee, Spouse/Registered Partner, & Children

R&C = Reasonable and Customary

	Deductible			Covered Expenses		Annual Out-of-Pocket Maximum (includes copays)		
	Tier I	Tier II & III	Tier IV	Plan Pays	You Pay	Tier I	Tier II & III	Tier IV
In-Network Only	None			100%	Copay	$1,000 / $2,000		
Lifetime Maximum				$2,000,000 per covered individual				

This benefit description is intended to be a brief outline of coverage and is not intended to be a legal contract. Benefits are described more fully in the plan document, which is available for review at the Battelle office that administers this Plan for you. In the event of a conflict between the plan document and the description provided herein, the terms of the plan document will prevail. This material is for informational purposes only and it is not intended to serve as a legal interpretation of benefits. Reasonable effort is made to have this material represent the intent of the Plan language. However, the plan document stands alone and is not considered as supplemented or amended in any way by the explanations or examples included in this material.

MEDICAL EXPENSES

Description of Medical Plan Coverage		Anthem BCBS Plan
Ambulance	Charges for professional ambulance services to or from the nearest hospital.	Covered in full for in-network providers. Covered in full for out-of-network providers for emergency use only.
Cosmetic Surgery – Elective	Charges for elective cosmetic surgery.	Not covered.
Dental Services	Charges for dental work necessitated by accidental injury to natural healthy teeth while covered under this Plan.	Covered in full after ER or office visit copay for initial treatment for damage to sound, natural teeth resulting from accidental injury that happens while covered by this Plan. Copay amount dependent on place of service.
Durable Medical Equipment (DME)	Charges for rental or purchase of durable medical equipment (DME).	Covered in full.
Education and Training	Charges in connection with custodial care, education or training, including orthoptic or vision training.	Not covered.
Emergency Health Services	Emergency care, including Hospital Emergency Room, Alternate Facility, or Urgent Care Center.	Emergency room In- and out-of-network covered in full after $75 copay for treatment of life-threatening emergency. Copay waived if admitted. 24-hour notification required following treatment. Urgent Care Center: Covered in full after $25 copay. Out-of-network *not* covered.
Excess of Reasonable and Customary (R&C) Charges	Charges made which are in excess of R&C charges as determined by this Plan.	Participant not responsible for charges by in-network providers over and above the contracted allowable charges.

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Experimental Procedures, Investigational or Unproven Treatment or Supplies	Services, treatment or supplies which are experimental, investigative, or unproven in nature.	Not covered.
Eye Examination	Eye exams received from a health care provider in the provider's office. One vision exam covered each calendar year.	Covered after $20 copay. Limited to one examination per covered person per year.
Felony/Illegal Occupation/Riot	Charges incurred as a result of a felony, illegal occupation or voluntary participation in a riot.	Not covered.
Hospice Care	Hospice care that is recommended by a Physician and the care is received from a licensed hospice agency.	Covered in full.
Hospital – Inpatient	Charges for hospital bed and board, limited to the hospital's most common semi-private daily rate. See "Mental Health/Substance Abuse" for other limitations.	Covered in full after $100 copay per admission – unlimited days in semiprivate room.
Hospital - Outpatient	Charges by a hospital for medical care and treatment on an outpatient basis. See "Mental Health/Substance Abuse" for other limitations.	Covered in full after $50 copay for outpatient surgery. All other outpatient services covered in full.
Hospital – Preadmission Testing	Charges for preadmission testing prior to hospital confinement.	Covered in full.
Infertility Services	Charges for diagnosis and treatment of infertility.	Office visits and tests are covered in full after $20 copay up to time diagnosis is finalized. Covers diagnosis only.
Injections	Charges for injections received in a Physician's office when no other health service is received; for example, allergy immunotherapy.	Allergy injections and/or serum covered in full. If office visit is rendered, $20 office copay may be charged. Routine immunizations and inoculations covered in full after $20 copay.
Laboratory Services and X-rays	Diagnostic x-rays and laboratory services; x-ray, radium and radioactive isotope treatment; oxygen and other gases and administration thereof; blood transfusions and blood not donated or replaced; anesthesia and its administration.	X-rays and laboratory tests covered in full in physician's office after $20 copay. Tests at medical facilities covered in full.
Maternity Benefit	Charges for pregnancy expenses for covered female members only. Coverage for pregnancy ceases when Plan coverage terminates.	First pre-natal visit is subject to $20 office copay. Professional services are covered in full. Hospital and delivery covered in full after $100 copay. Dependent children are covered.
Mental Health/Substance Abuse (MH/SA)	Charges for EEX expenses rendered in a physicians office or other appropriate facility, incurred because of mental health or substance abuse. Subject to coordination of care prior to inpatient admission.	**Inpatient:** Covered in full after $100 copay per admission up to 30 days per calendar year. **Outpatient:** Covered in full after $20 copay per visit, up to 50 visits per calendar year. Inpatient and outpatient substance abuse programs limited to two per lifetime.

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Nutritional Counseling	Covered health services provided by a registered dietician in an individual session for covered persons with medical conditions that require a special diet.	Diabetic education and certain medical nutritional therapy covered in full after $20 copay.
Obesity Surgery	Charges for or in connection with surgery due to obesity.	Not covered.
Physician Services	Charges for professional services of physicians (unless practitioner is a family member).	Covered in full after $20 copay per visit. No referral from Primary Care Physician required to see a specialist. Naturopaths not covered. Allergy Testing covered in full.
Prescription Drugs	Drugs and medicines requiring a physician's (or dentist's) prescription for a specific illness and dispensed by a pharmacist.	**Retail Pharmacy** (30-day supply) ▪ Generic: $15 copay ▪ Preferred: $30 copay ▪ Non-Preferred: $40 copay **Mail Order** (90-day supply) – offered through APM ▪ Generic: $20 copay ▪ Preferred: $60 copay ▪ Non-Preferred: $80 copay Benefits are not available for all drugs. Some benefit limitations and prior authorization may apply for certain prescription drugs. **Maintenance Medications:** Medications taken on a routine basis must be ordered through **Mail Order.** However, when first starting the medication you are permitted to use **Retail** for the initial 30 day prescription and two 30-day refills. **Retail and Mail Order**: If your prescription is filled with a brand name drug when a generic is available, you will be responsible for paying both your copay and the price difference between the brand name and the generic drug.
Preventive Care	Routine physical examinations including ▪ Hearing screenings ▪ Colonoscopy and sigmoidoscopy once every 5 years after age 50 ▪ Pap smears, pelvic exams and mammograms once per calendar year unless deemed necessary by your provider, ▪ Well-woman, well-man and well-child services	Covered in full after $20 copay. Hearing examination $20 copay, limited to one examination per covered person per year. Cost of Hearing Aid not covered. (Discounts available – see "Special Offers" section on Anthem web site.) No annual maximum.

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Private Duty Nursing	Nursing services ordered by a physician and provided by or supervised by a registered nurse in your home. Benefits available only when skilled care is required. Custodial care is not covered. It is not covered when the caregiver is a member of the retiree's or dependent's family.	Covered in full.
Provider Relationship	For services rendered by a person who is an immediate relative of or who ordinarily resides with the covered person requiring treatment.	Not covered.
Reconstructive Procedures	Charges for reconstructive surgery only when necessitated by disease or accidental injury while covered under the Plan. The primary purpose must be to restore physiologic function for an organ or body part.	Covered in full when necessitated by disease or accidental injury while covered under this Plan.
Rehabilitation Services – Outpatient Therapy	Charges for the following therapies: physical, occupational, speech, pulmonary rehabilitation, cardiac rehabilitation. *Massage therapy is not a covered benefit.*	Covered in full after $20 office copay. Covered in full for outpatient facility. Annual Therapy Limits: • Physical Therapy: 30 visits • Occupational Therapy: 30 visits • Speech Therapy: 20 visits
Reimbursement	To the extent that the person is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any other source.	Not covered.
Sex Change	Charges for or in connection with sex change, transsexual surgery and/or treatments related to or leading to transsexual surgery.	Not covered.
Sexual Dysfunction	Charges for or in connection with sexual dysfunction.	Not covered.
Skilled Nursing Facility	Charges by a qualified special care facility for medical care and treatment, with charges for accommodations not in excess of the rate of the facility's most common rate for semiprivate accommodations.	Covered in full after $100 copay. Subject to coordination prior to admission.
Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy	Benefits available when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services.	Covered in full after $20 copay. Spinal manipulation covered to a maximum of 12 visits per year. Acupuncture not covered.
Sterilization	Sterilization of an employee or spouse.	Covered in full after copay. Copay amount dependent on place of service. Reversal of sterilization not covered.
Transplant Services	Covered for certain organ and tissue transplants when ordered by a physician. Transplantation services must be received at a designated Blue Quality Centers for Excellence in the United States to be covered. Subject to coordination of care prior to admission.	Covered in full for bone marrow, heart, heart/lung, liver, pancreas, or kidney/pancreas transplant services received at Blue Quality Centers for Excellence. Kidney and cornea transplant services paid as any other service under medical.

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Vision—Hardware	Charges for eyeglasses, contact lenses, examination for prescription eyeglasses or contact lenses. See *Eye Examinations*	Maximum benefit of $150 in a rolling 24-month period.
Wellness Care	Example Charges: well-man, well-woman, newborn, well-baby and well child care and examinations (including pap smears, mammography and colon screening, physical exam, prostate exam, etc.) in accordance with Plan guidelines.	Covered in full after $20 copay per visit including office visits, consultations, pap smears, mammograms, routine physical examinations, well-baby care.
Workers' Compensation, Government Hospital, Payments Prohibited by Law and Payments Not Required	Charges for or in connection with a sickness or injury for which a person is entitled to benefits under Workers' Compensation or similar law. Charges for treatment in a hospital owned or operated by the U.S. Government, and for which no charge is made. Charges for which payment from the Plan is prohibited by any law applicable to the person at the time the charges are incurred. Charges, which the person is not legally required to pay, or which would not have been made if no insurance existed.	Not covered.

MANDATED MEDICAL BENEFITS		
Description of Medical Plan Coverage		**Anthem BCBS HMO**
Mandated Health Benefits	Federal law requires group health plans to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy if agreed to by the patient and attending physician: • Reconstruction for the breast on which the mastectomy was performed. • Surgery or reconstruction of the other breast to produce a symmetrical appearance. • Prostheses, and • Physical complications for all stages of a mastectomy, including swelling associated with the removal of lymph nodes. This coverage would be made available to participants or beneficiaries who are receiving benefits in conjunction with a mastectomy and who elect breast reconstruction.	Covered. Copays and coinsurance for related services may apply and are subject to provisions consistent with other benefits under the Plan.

MANDATED MEDICAL BENEFITS		
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Mandated Maternity Benefits	The Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for normal or vaginal delivery or less than 96 hours for a cesarean section. However, the Plan does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan shall not require that a provider obtain authorization from the Plan of prescribing a length of stay not in excess of 48 (or 96 hours, if applicable).	Covered in full.